Statement of Educational Philosophy
UCSF School of Dentistry

We, the faculty, students and staff of the UCSF School of Dentistry, are committed to fostering an environment of mutual trust and respect. We believe this goal requires clear communication, compassion for others, and enthusiasm for the dental profession. To this end, we accept personal responsibility for our interactions with patients and colleagues and we encourage one another through constructive guidance. This team philosophy will be the foundation of all our endeavors, even in challenging times. In this way, we will continue to achieve academic and clinical excellence, create lifelong professional partnerships, and provide lasting contributions to the greater community.

7/28/2008

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
DENTAL SERVICES

PARNASSUS CLINICS
707 PARNASSUS AVE.
(415) 476-1891
TDD: (415) 476-1778

BUCHANAN DENTAL CENTER
100 BUCHANAN
(415) 476-5608

Dental Patient Bill of Rights and Responsibilities

The Patient Rights and Responsibilities printed below apply to every patient in our clinics with the understanding that the University of California, San Francisco, in conformance with the applicable laws and regulations, does not discriminate on the basis of race, color, national origin, gender, handicap, sexual orientation, or age. We encourage patients to be informed about all aspects of their care. Your dental care provider and teaching faculty are the best persons to ask about the treatment and care you receive at the school.

All Patients Of The School of Dentistry Have A Right To:

- Considerate and respectful care.
- Know the name of the dental care provider.
- Be informed of risks as well as the nature of procedures, expected benefits, and the availability of alternative methods of treatment and the risk of no treatment.
- Ask your dental provider to discuss all the treatment options regardless of coverage or cost.
- Know in advance the type and expected cost of treatment.
- Examine and receive an explanation of the statement of charges.
- Be informed of continuing dental health care requirements.
- Reasonable continuity of care and completion of treatment.
- Expect dental team members to use appropriate infection and sterilization controls.
- Privacy concerning the dental care program.
- Confidentiality of all communications and records pertaining to care. You are entitled to access the information contained in your patient record, within the limits of the law.
- Have these patient rights apply to the person who may have legal responsibility to make decisions regarding dental care on behalf of the patient.

- Treatment that meets the Standard of Care
- To express concerns or complaints about your care with the assurance that the presentation of a complaint will not compromise the quality of your care.
- Exercise these rights and have reasonable access to treatment in clinics.

As a patient at the Dental Clinics at UCSF, you also have the following **Responsibilities:**

- To report to the best of your knowledge, accurate and complete information regarding any matters pertaining to your health to your dental provider and other health care professionals caring for you.
- To follow the treatment plan recommended by your dental provider (subsequent to informed consent and your authorization to begin treatment)
- To keep appointments.
- To accept the consequences of your own decisions and actions, if you choose to refuse treatment or not to comply with the instructions given by the dental provider.
- To assure that your financial obligations for your health care are fufilled as promptly as possible.
- To follow Dental Clinics rules and regulations affecting patient care and conduct.
- To respect the rights and property of other patients and Dental Clinics personnel, including no cell phone use in the patient reception and treatment areas.
- To follow the UCSF smoke free policy.

University of California
San Francisco
UCSF
School of Dentistry

NEW PATIENT INFORMATION

Welcome to the UCSF School of Dentistry Dental Clinics!

We are located at 707 Parnassus Avenue, San Francisco, California 94143-0752 For information and or appointments in our clinic, please call (415)476-1891 or visit our website http://dentistry.ucsf.edu/patients/patients_main.html

Dental care in the ***Predoctoral practice*** is provided by dental students under the direct supervision of faculty dentists. The purpose of your first visit with us is to assess your overall dental conditions and report our limited findings. **There is a $11 fee for this assessment**. In addition, our evaluation allows us to determine which of our three clinical practices would best fit your needs if you choose to become a patient in the School of Dentistry. Our three practices are: the Predoctoral Clinic, the Postgraduate Clinics, and the Faculty Group Practices. While it takes longer to complete treatment than in a private office (most appointments last approximately three hours), the fees in the Predoctoral clinic are generally less than the cost of a private office. Patients with complex dental or health conditions or treatment needs are beyond the scope of the Predoctoral Clinics. These patients will be referred to more advanced providers. When the initial evaluation is completed you will be assigned to one of our three practices based on a discussion with you about which practice best fits your dental and health needs. If you become a patient in the Predoctoral clinic, you will be assigned to a primary and possibly a secondary student co-provider.

You will be given an appointment as soon as possible. Please be prompt or early to your appointed time, which is reserved for you. If you are unable to keep your appointment, please call us at (415) 476-1891 so that we can reschedule your appointment. **There will be a charge of $10 for each broken appointment or when you cancel your appointment with less than 24 hours advance notice. The dental chair assigned for you and your student-dentist is reserved until twenty minutes after your appointed time. After that, the chair is reassigned to another student-dentist and you will be charged a broken appointment.**

Your first appointment as a ***patient of record*** in the Predoctoral clinic will be to start your comprehensive oral examination (complete set of X-rays are necessary), discuss our findings and formulate a plan to restore your dental health and implement preventive care to reduce or eliminate future dental disease. We encourage you to ask questions if you need information or clarification on our clinic policies, procedures or treatment modalities. If you have x-rays from a previous dentist, please bring them with you if possible. If you do not have recent, acceptable x-rays, we can take them at the school.

Treatment in the Predoctoral Clinics must be paid in-full at the time of service. We cannot make future appointments for patients with an account balance. As a convenience for our patients, we do accept major credit cards and checks.

If you are referred to either a Postgraduate or Faculty dental practice, you will be given the appropriate telephone number to call at your convenience to schedule a comprehensive examination or consultation appointment.

Dental care in the ***Postgraduate Clinics*** is provided by dentists taking advanced training in specialty areas. The fees are higher than the Predoctoral clinic, but less than those of a private dentist.

Dental care in the ***Faculty Group Practices*** is provided by the teaching faculty in group dental practice settings and the fees are similar to those in the community.

THANK YOU FOR THE OPPORTUNITY TO SERVE YOU!

UCSF SCHOOL OF DENTISTRY
Patient Registration Form

CONFIDENTIAL

Date_____

1. Name_____
Last First MI

2. Gender (Circle) Male Female Transgender

3. Date of Birth:_____ SS#: _____

4. Street Address:_____

5. City:_____ State:_____Zip Code:_____

Please place an asterisk (*) Next to the best phone number to contact you below!

6. Home Phone: ( ) _____Work Phone : ( ) _____

Cell Phone: ( ) _____ Other Phone: ( ) _____

7. Do you have Denti-Cal (Welfare) or Private Insurance (Circle): **Yes** **No**
"Please present Denti-Cal-Card/Insurance Card and Valid California ID to the staff"

8. Disability(circle) Yes No If yes, please indicate: Partial Total
Temporary Permanent

_____

9. Please select your racial background (You may select more than one):

___African-American/Black/Haitian
___American Indian /Native Amer/Alaskan Native
___Bangladeshi
___Burmese/Myanmarese
___Caucasian /white/Middle Eastern
___Chinese
___Central American
___Cuban
___Fijian
___Filipino
___Guamanian
____Hawaiian
____Indian
____Indonesian
____Japanese
____Korean
____Laotian
____Malaysian
____Mexican/Latino/American
____Other Asian
____Pakistani
____Thai
____Do not wish to respond

10. In order to IMPROVE our oral health services for you-our patients-please indicate the languages you speak, and if you need a clinician who speaks this language.

Language Spoken: Mark ALL that apply.

___English	___Mandarin	___Farsi	___Tagalog
___Spanish	___Korean	___Tagalog	___Hindi
___Cantonese	___Russian	___Other _____	

Do you need an interpreter? (circle) **Yes** **No**

11. How do you hear from about UCSF Dental School: _____

Emergency Contact Information
Name of significant other/closest relative_____Relationship_____
Home Phone: ( ) _____Cell Phone:_____Work Phone:_____
In Case we cannot reach this contact person; Back -up person contact:
Name: _____ Phone number:_____Relationship:_____

Financial Responsible Party (If it is the same as the patient, proceed to Insurance Information).

Name:_____Relation to Patient_____
Last First MI
Social Security Number: _____Date of Birth:_____
Phone number:( )_____ Work number: ( ) _____
Cell number: ( ) _____ Contact E-mail_____
Street Address:_____
City:_____State:_____Zip Code:_____

Dental Insurance Information

Insurance Name: _____ Group number:_____
Policy Number: _____ Effective Date:_____
Mailing Address:_____ Phone number:( ) _____

Do you have other DENTAL coverage?(circle) **Yes** **No**
If yes, please fill out the information below for the second coverage.

Policy Holder's Name:_____Date of Birth:_____
Last First MI
Social Security #: _____ Gender: Male Female Transgender
Phone number: ( )_____Relationship to Patient_____
Insurance Name: _____Group number_____
Policy Number: _____Effective Date:_____
Mailing Address:_____

UCSF SCHOOL OF DENTISTRY
Medical History

CONFIDENTIAL

Consents/Cultural Considerations

1. Do you sign your own consents for health care? Y N
   a. If you are completing these forms for the patient, please print your name and state your relationship to the patient? (Specify) _____
2. Which languages do you speak? _____
3. Do you have any personal or cultural health beliefs that are important for us to know? Y N
   a. If yes, please specify: _____
4. In case of an emergency, whom should we contact? (Name) _____
   a. What is his/her phone number? (Specify) _____
   b. Relationship to patient? Spouse ____ Legal Guardian ____ Son ____ Daughter ____ Other (Specify) _____

Medical History

5. Has there been a change in your general health within the last year or since your last visit? Y N
   a. If yes, please specify: _____
6. When was your last complete medical examination? Specify Year _____ Do not remember____
7. Have you had any illness, condition or accident that required surgery or hospitalization in the past 2 years? Y N
   a. If yes, please specify:_____
8. Do you have any surgery or hospitalization planned? If yes, please specify_____ Y N
9. Do you currently have a physician or primary care doctor? Y N
   a. Name, Location and Phone Number: _____
10. Do you have any medical problems requiring ongoing care and monitoring? Y N
    a. If yes, please specify:_____

Illnesses:

Do you have or had in the past any of the following?

11. Blood Disease, Condition, or Bleeding disorder? Y N
    - o Anemia
    - o Bleeding Disorder (Specify) _____
    - o Deep vein thrombosis
    - o Leukemia (Specify type) _____
    - o Lymphoma (Specify type) _____
    - o Multiple myeloma
    - o Sickle cell disease
    - o Von Willebrand's disease
    - o Other (Specify) _____

12. Cancer or Tumor? Y N
    - o Benign or Malignant (Specify) _____
    - o Location of tumor (Specify) _____
    - o Date of diagnosis _____
    - o Type of treatment (Specify) _____
      - □ Surgery Y N
      - □ Radiation Y N
      - □ Chemotherapy Y N
    - o Other (Specify) _____

13. Eating Disorder? Y N
- o Anorexia
- o Bulimia
- o Other (Specify) _____

14. Emotional disorders? Y N
- o ADD/ADHD
- o Anxiety
- o Bipolar/Manic-depressive
- o Depression
- o Post-traumatic stress disorder
- o Schizophrenia
- o Other (Specify) _____

15. Endocrine disease? Y N
- o Adrenal gland disorder (Specify) _____
- o Diabetes
  - □ Type 1
  - □ Type 2
  - □ Gestational
  - □ Blood Sugar Level (Specify) _____
  - □ A1c level (Specify) _____
- o Thyroid problems
  - □ Hypothyroidism
  - □ Hyperthyroidism
- o Other (Specify) _____

16. Gastrointestinal (stomach, intestine, or colon)? Y N
- o Acid reflux (GERD)
- o Ulcers
- o Other (Specify) _____

17. Heart Disease? Y N
- o Angina (chest pain)
- o Arrhythmia (irregular heart beat)
- o Artificial heart valves
- o Congenital heart defect
- o Coronary heart disease
- o Endocarditis
- o Heart attack: Date(s) _____
- o Heart failure
- o High blood pressure (hypertension)
- o Implanted defibrillator
- o Low blood pressure
- o Mitral valve prolapsed
- o Pacemaker
- o Rheumatic heart disease
- o Other (Specify) _____

18. Infectious disease? Y N
- o Methicillin-Resistant Staphylococcus Aureus (MRSA)
- o HIV
  - □ What is your CD4 (T-cell) count? (Specify)_____
  - □ What is your viral load? (Specify) _____
- o Human Papillomavirus (HPV)
- o Immunosuppression
- o Oral herpes
- o Mononucleosis
- o Syphilis
- o Other (Specify) _____

19. Kidney disease or disorder? Y N
- o Renal failure/insufficiency
- o Other (Specify) _____

20. Liver disease such as cirrhosis or hepatitis? Y N
- o Cirrhosis
- o Hepatitis (Circle one) A B C D Other Hepatitis (Specify) _____
- o Other (Specify) _____

21. Lung, breathing or sinus problems, respiratory diseases or conditions? Y N
- o Asthma
- o Bronchitis
- o Emphysema
- o Pneumonia
- o Sarcoidosis
- o Sleep apnea
- o Sinusitis
- o Tuberculosis
- o Other (Specify) _____

22. Muscle/bone/connective tissue disease or disorder? Y N

- o Arthritis (Specify type) _____
- o Fibromyalgia
- o Lupus
- o Osteonecrosis
- o Osteoporosis
- o Scleroderma
- o Sjogren's Syndrome
- o Other (Specify) _____

23. Neurologic (nerve) diseases or conditions? Y N

- o Dementia/Alzheimer's
- o Multiple sclerosis
- o Nerve pain (Specify) _____
- o Parkinson's disease
- o Stroke
- o Seizures/Epilepsy
  - □ Grand mal
  - □ Petite mal
  - □ Other (Specify) _____
- o TIA (transient ischemic attack)
- o Other (Specify)

24. Organ transplant? Y N

- o Date: _____
- o Which organ(s)? _____
- o Other (Specify) _____

25. Prosthetics (artificial) joints, knees, or hips? Y N

- o Knees
- o Hips
- o Other (Specify) _____

FOR WOMEN

26. Are you trying to become pregnant? Y N

27. Are you currently pregnant? Y N

If yes, number of weeks pregnant? _____ Expected due date? _____

28. Are you currently breastfeeding? Y N

MEDICATIONS

29. Do you take any prescribed medications? Y N

Please list all prescribed medications including dose and frequency _____

_____

_____

_____

Please list all over the counter vitamins, supplements or herbal remedies _____

_____

_____

_____

ALLERGIES

30. Are you allergic or had a bad reaction to any of the following? Y N

- o Antibiotics (Specify antibiotic and reaction) _____
- o Local anesthetics ((Specify anesthetic and reaction) _____
- o Latex (rubber) (Describe reaction) _____
- o Metals (Specify metal and reaction) _____
- o Pain medications (Specify medication and reaction) _____
- o Other medications (Specify medication and reaction) _____

SOCIAL HISTORY

31. Do you use or have you used tobacco (smoking, snuff, chew, bidis)? Y N

Past Use (Check all that apply)

- o Bidis Specify amount per day _____ How many yrs? _____ When did you stop? _____
- o Chewing tobacco Specify amount per day _____ How many yrs? _____ When did you stop? _____
- o Smoking Specify amount per day _____ How many yrs? _____ When did you stop? _____
- o Snuff Specify amount per day _____ How many yrs? _____ When did you stop? _____

Currently Using (Check all that apply)

o	Bidis	Specify amount per day: _____	How many yrs? _____
o	Chewing tobacco	Specify amount per day: _____	How many yrs? _____
o	Smoking	Specify amount per day: _____	How many yrs? _____
o	Snuff	Specify amount per day: _____	How many yrs? _____

32. Are you interested in stopping tobacco use? Y N

33. Do you drink alcoholic beverages? Y N

- o How many drinks do you typically have in a day? _____
- o How many drinks do you typically have in a week? _____
- o Have you received treatment for alcohol dependence condition? Y N

34. Are you interested in stopping alcohol abuse? Y N

35. Do you use prescription drugs, street drugs or other substances for recreational purposes? Y N

- o Cocaine (Specify frequency) _____
- o Ecstasy (Specify frequency) _____
- o Marijuana (Specify frequency) _____
- o Methamphetamine (Specify frequency) _____
- o Heroin (Specify frequency)
- o Oxycontin (Specify frequency) _____
- o Other (Specify frequency) _____

36. Are you interested in stopping drug abuse? Y N

UCSF SCHOOL OF DENTISTRY

Dental- Related History Form

CONFIDENTIAL

Date:_____

1. What is the reason for your visit today? _____
   _____
2. Are you in pain or discomfort today? Y N
   Rate pain severity on 0-10 scale with zero= no pain and ten = worst pain
   0 1 2 3 4 5 6 7 8 9 10
   Please explain: (Include characteristics of pain: location, onset, duration, sharp or dull, known cause, aggravators/relievers, taking any medication to relieve pain?)_____
   _____
3. Any thoughts about what might be causing your dental problems?_____
4. Have you had any negative experiences at the dentist or during dental treatment? Y N
   Please explain:_____
5. How much worry, fear, or anxiety do you experience at the dentist? Rate fear 0 – 10:
   0 1 2 3 4 5 6 7 8 9 10
6. Any trouble sleeping the night before a dental appt or fainting during an appt?
   Please explain:_____
7. Is there anything we could do to make you more comfortable?
   Please explain:_____
8. Do you clench or grind your teeth? Y N
9. Do you have trouble getting or staying numb with dental anesthesia? Y N
   Please explain:_____
10. Is your bite uncomfortable? Y N
    Please explain:_____
11. Are your teeth sensitive to cold, hot, sweet, or pressure? (circle all that apply)
    Cold Hot Sweet Pressure
12. Do you have pain or numbness in your lips, tongue, or soft areas of mouth? (eg. gums/ under the tongue, cheeks) Please explain: _____
13. Do you have any pain or numbness in your ears, scalp, temples, or jaw?
    Please explain:_____
14. Do you have difficulty chewing or swallowing?
    Please explain:_____
15. Do you have a problem with acid reflux, vomiting, or weight loss?
    Please explain:_____
16. Do you have any swelling in your face, neck, or any part of your mouth?
    Please explain:_____
17. Do you have any bleeding when brushing or flossing?
    Please explain:_____
18. Do you have trouble cleaning your teeth?
    Please explain:_____
19. Are there any teeth, in particular, you are worried about losing?_____

(OVER)

Now or in the past, have you ever had:

20. Any difficulty opening or closing or locking in your jaw?
    Please explain:_____
21. Any braces or orthodontic work to straighten your teeth?
    Please explain:_____
22. Any extractions, oral surgery, or tooth implants?
    Please explain:_____
23. Any family history of losing teeth early?
    Please explain:_____
24. Any gum or periodontal surgery?
    Please explain:_____
25. Any root canal or endodontic treatment?
    Please explain:_____
26. Do you have a partial or complete denture? Indicate which: partial or complete
27. Any problems with your denture?
    Please explain:_____
28. Who was your previous dentist? _____
    What led up to leaving his/ her care?_____
29. List name, address, phone number of dentist? _____
    _____
    Date of most recent dental Xrays?_____
30. Date of last dental cleaning? _____